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Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018

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The past year saw multiple developments that could affect payment reform—a new administration was getting up to speed, the Affordable Care Act (ACA) was debated and its implementation modified through legislative and regulatory changes, and questions were raised about the future of alternative payment models. Despite this, implementation of the *Medicare Access and CHIP Reauthorization Act* (MACRA) and its associated programs continued, private payers continued to highlight their commitment to value-based care, and many states took steps on payment reform in their Medicaid programs.

Leavitt Partners, in partnership with the Accountable Care Learning Collaborative, tracks the growth and spread of accountable care organizations (ACOs) and other alternative payment models. To gauge where the field is currently, we present the most

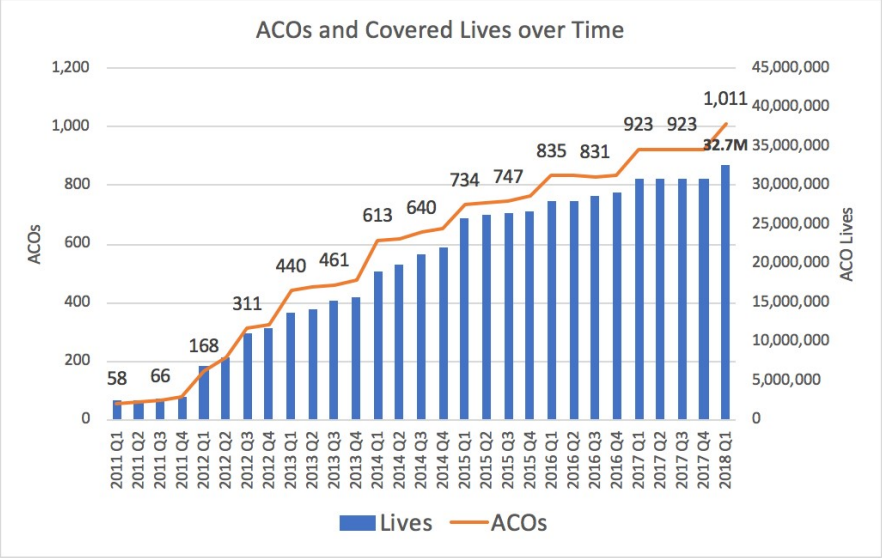
recent figures on ACO and value-based payment (VBP) adoption, and assess the implications of these trends for the upcoming year. We find that, despite the past year's uncertainty around federal policies and the future of value-based care, the health care system continues to adopt new payment and delivery models.

ACO Growth: Still Rising

At the end of the first quarter of 2018, we were tracking a total of 1,011 ACOs representing 1,477 distinct active accountable care payment contracts with public and private payers. Combined, these contracts cover about 32.7 million patients in all regions of the country. Exhibit 1 shows the growth in ACOs and lives over time. Driven primarily by growth in Medicare ACO programs, the overall numbers of ACOs and ACO contracts continued to increase through the first quarter of 2018. (Note that estimates of covered lives and geographic growth are made with a refined methodology from previous years and do not exactly match previous reports.) As a result, about 10 percent of the US population is now covered by an ACO, representing an increase of about two million people (about 6 percent)

compared to the previous year's revised estimates.

Exhibit 1: Accountable Care Contracts And Lives Covered Over Time



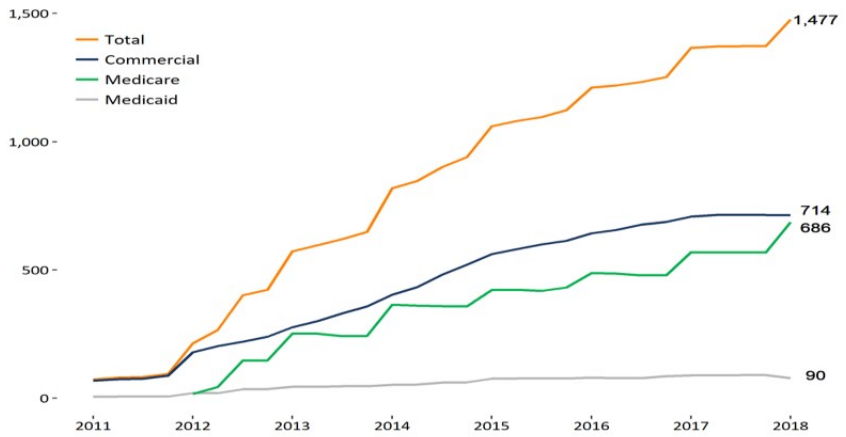
Source: Authors' analysis of Leavitt Partners' accountable care organization (ACO) database.

In the first quarter of 2018, commercial ACO contracts accounted for a little more than half of all ACO covered lives, while Medicare contracts accounted for 37 percent, and Medicaid contracts accounted for the remaining 10 percent (not shown). Despite being almost equal in numbers, commercial contracts tend to cover more lives than Medicare contracts (24,300 versus 17,500 lives on average). Medicaid contracts have by far the highest number of lives per contract,

at 43,500 on average.

Exhibit 2 shows the number of ACO contracts over time broken down by Medicare, Medicaid, and commercial arrangements. There are slightly more commercial ACO contracts than Medicare (48 percent versus 46 percent), with Medicaid contracts making up 5 percent. While Medicare ACO contracts continued to grow, commercial contracts saw very little net growth in 2017, and Medicaid contracts saw a slight contraction as some state demonstration programs were not renewed.

Exhibit 2: Accountable Care Contracts Over Time



Source: Authors' analysis of Leavitt Partners' accountable care organization database.

A number of reasons may underlie this pause. Changes in federal administration and

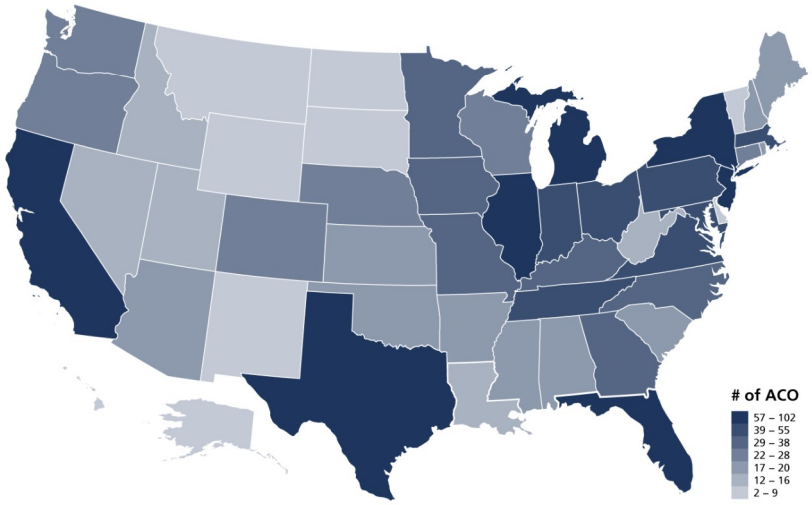
questions about whether and how the government would support VBP models created significant uncertainty about ACOs. Some providers we spoke with stated that they decided to take a “wait and see” attitude toward developing new commercial contracts. Many health plans said that they were gradually and thoughtfully expanding their population health accountability programs given the federal uncertainty. At the same time, Medicare ACO contracting opportunities remained available, providing a pathway for MACRA reporting and (in “advanced” ACO contracts, such as the Next Generation ACOs) additional physician payment. A substantial part of the growth occurred in “two-sided risk” contracts, with 76 new contracts (or 48 percent) in Medicare Shared Savings Program (MSSP) Tracks 1+, 2, 3, or the Next Generation ACO demonstration. Twenty-seven of these new two-sided risk contracts were with ACOs that had not been in any Medicare programs before.

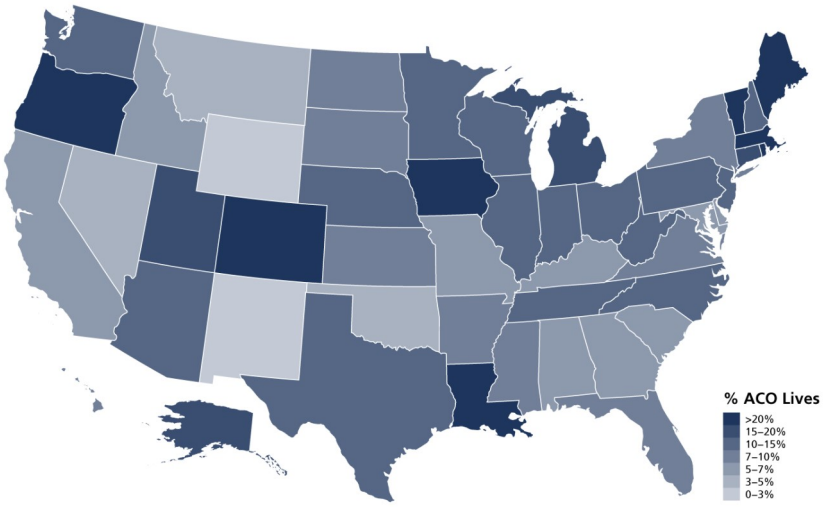
Geographic Dispersion Of ACOs

Exhibit 3 shows that all states now have more than 2 percent of their population

covered by accountable care contracts, and some have much more. Three states (Rhode Island, Massachusetts, and Maine) have more than 30 percent penetration, and five more states (Colorado, Oregon, Vermont, Iowa, and Louisiana) and the District of Columbia have more than 20 percent. Some of these states with higher proportions have smaller populations, so smaller absolute growth in ACOs leads to a large change in penetration. However, accountable care initiatives in some of these states have had an impact. For example, Oregon has implemented coordinated care organizations in its Medicaid program (with other payers participating), and Blue Cross Blue Shield of Massachusetts implemented an ACO model through its alternative quality contract. Most states saw at least a slight increase in ACO penetration compared to 2017.

Exhibit 3: Total Number Of ACOs And Percentage Of Population In An ACO By State



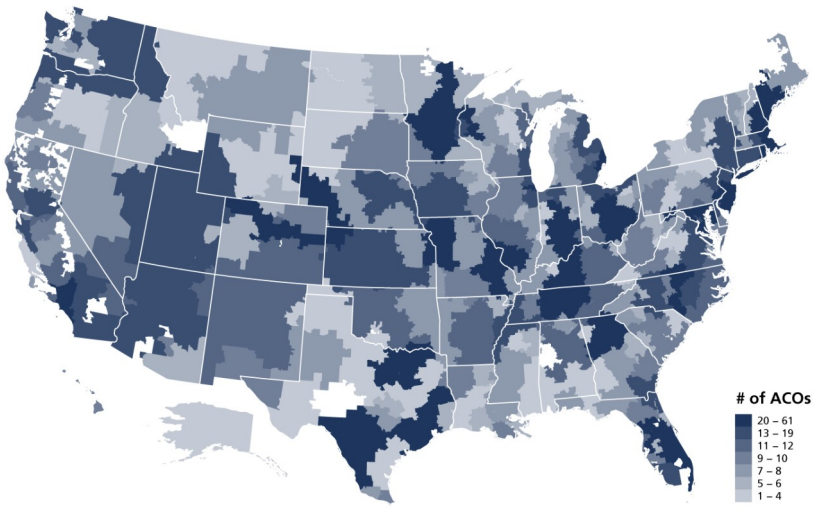


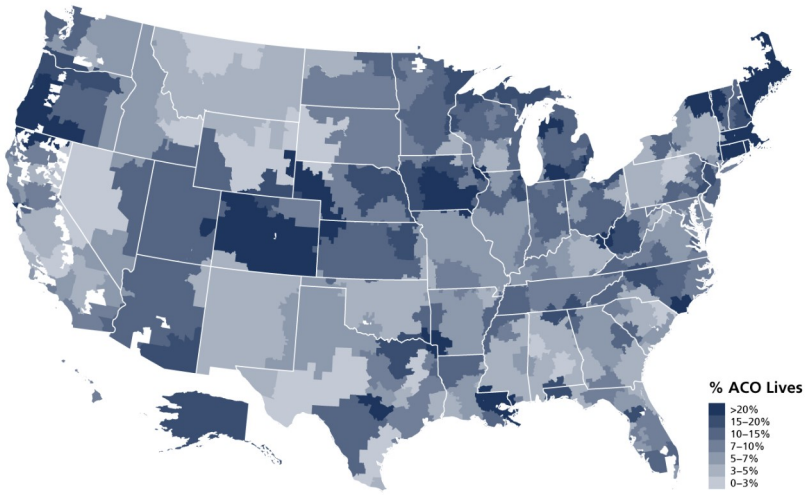
Source: Authors' analysis of Leavitt Partners' accountable care organization (ACO) database.

Similarly, Exhibit 4 shows that there are now at least some ACO lives in each of the 306 hospital referral regions (HRRs), but there is considerable variation at the HRR level. Nationwide, 14 HRRs have less than 2 percent penetration, and 5 of those have less than 1,000 covered lives. At the other side of

the spectrum, 14 HRRs have reached 30 percent penetration. Penetration continues to vary within many states; for example, Texas has regions in the top and bottom of the rankings. Areas with high regional penetration include markets driven by a large provider adopting accountable care, as well as many smaller competitors that each form an ACO. Both rural and urban types of HRRs have similar ACO penetration.

Exhibit 4: Total Number Of ACOs And Percentage Of Population In An ACO By Hospital Referral Region





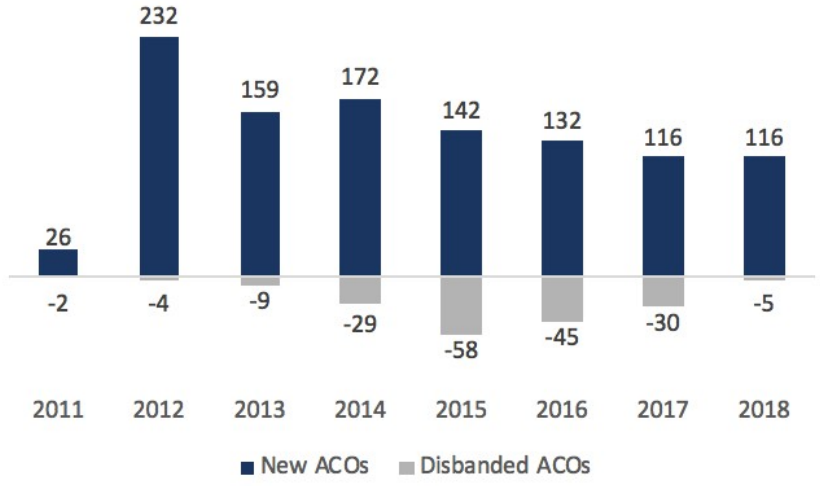
Source: Authors' analysis of Leavitt Partners' accountable care organization database.

Survival In The ACO Program

While the net number and penetration of ACOs is rising, some ACOs have dropped out. Altogether, 232 new ACOs were created during 2017 and the first quarter of 2018; during the same time frame, 35 ACOs exited the program. Exhibit 5 displays entry and exit trends over time. Many ACOs have not yet succeeded in improving performance while lowering spending trends relative to their benchmark, and more provider organizations may exit ACO programs in the future. Learning more about the characteristics of those ACOs that leave will help inform program design.

Exhibit 5: ACOs Beginning And Ending

Service By Year



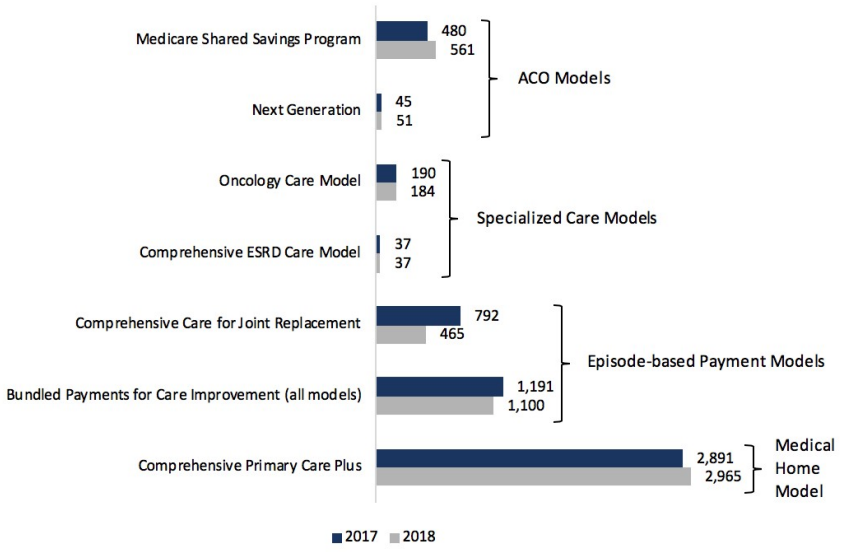
Source: Authors' analysis of Leavitt Partners' accountable care organization (ACO) database.

Growth Of Other VBP Arrangements

In addition to ACOs, other VBP models are continuing to grow. Exhibit 6 illustrates that while Medicare ACO programs continued to enroll new participants, and the Medicare advanced medical home program (Comprehensive Primary Care Plus, or CPC+) continued to expand, other ongoing demonstration models have either remained at the same participation levels or slightly declined. This is likely due to the limited new options for participating in other Medicare

VBP arrangements in 2017. Under then-Department of Health and Human Services (HHS) secretary Tom Price, in November 2017, the Centers for Medicare and Medicaid Services (CMS) cancelled two mandatory bundled payment models and reduced the number of mandatory geographic areas for the Comprehensive Care for Joint Replacement demonstration (leading to the large decline in that program shown in Exhibit 6). Additionally, the Center for Medicare and Medicaid Innovation (Innovation Center) had a leadership change, and its new director was not appointed until April 2018.

Exhibit 6: Medicare Alternative Payment Model Participants



Source: Authors' analysis of Medicare data.
Notes: ACO is accountable care organization.

ESRD is end-stage renal disease.

This decline may be temporary. On January 9, 2018, CMS announced the administration's first new alternative payment model demonstration, Bundled Payments for Care Improvement (BPCI) Advanced, which builds on the ongoing BPCI. CMS is currently processing applications for BPCI Advanced, which will likely lead to some increase in episode-based payment contracts. The agency has also signaled support for additional specialized-care models such as for advanced illness and direct provider contracting, although no new payment options are yet available.

Although CMS offered only limited new VBP options in the past year, commercial payers and self-funded employers continue to expand their bundled payment offerings. For example, UnitedHealth Group announced in May that it is expanding a bundled payment program for spinal surgeries and hip/knee replacements to new markets, after finding savings of $18,000 per procedure. Humana recently expanded a Medicare Advantage bundle program, and Walmart's newly announced direct ACO agreement with Emory Healthcare includes a bundled payment for spine surgery and joint replacement. The

considerable commercial activity around bundled payments and specialized care could be reinforced by further CMS initiatives.

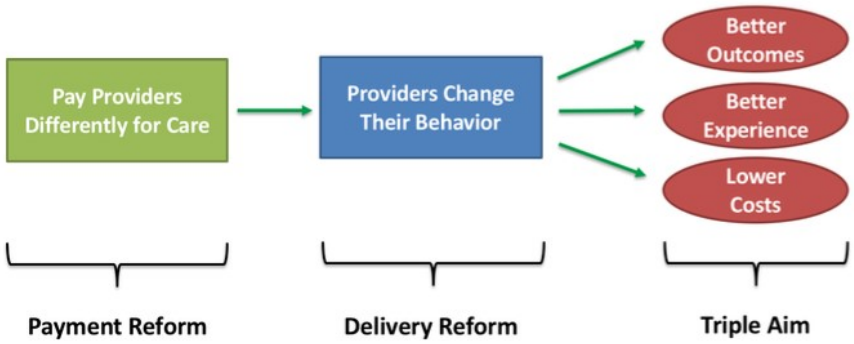
Translating Payment Reform Into Delivery Changes

While adoption of VBP models is important, it is only the means to the goal of changing the delivery of care to achieve better outcomes and lower costs (Exhibit 7). Delivery reform is challenging; it requires health care organizations to implement fundamental reforms in their administrative and clinical operations to shift the focus from providing specific services efficiently to providing longitudinal patient care effectively.

A major barrier to organizational redesign is the lack of a clear roadmap for change that providers can follow. Hundreds of ACOs and other organizations are implementing a wide range of steps to try to succeed, and organizations show more success over time. But the mixed results and significant variation across organizations show that much work remains to identify what changes, interventions, and programs are most likely to achieve short-term improvements. In the meantime, many organizations may continue

to struggle or remain uncertain about how to proceed, and some will continue to fall back to fee-for-service.

Exhibit 7: How Payment Reform Leads To Improved Performance



Source: Authors' analysis.

One impediment keeping providers from making major delivery system reforms is the limited business case for many of these organizations. Most provider organizations that have formed ACOs still have only a minority of their patients covered by alternative payment models and risk-based payments. Currently, ACOs see the need to experiment with risk-based payment models because they want to prepare for a potential future when such models are more prevalent. However, they are reluctant to undertake major delivery reforms that are not sustainable under the predominant fee-for-service payment model that still determines their financial success. To encourage

organizations to change how they deliver care, the depth of risk is important, but perhaps more important is the breadth of risk—what share of revenue is under value-based payment arrangements.

Accompanying a more compelling business case, organizations would benefit from clearer evidence and support for specific actions to succeed in the short term (the next one to three years). Progress can be accelerated through collaborative learning and the development of more sophisticated and effective private- and public-sector supports to reduce uncertainty for providers.

Policy Implications

While there was uncertainty in 2017 about the federal government's commitment to payment reform, there currently appears to be strong support among leaders in HHS. Secretary Alex Azar has made the transition to VBP one of his top priorities. CMS administrator Seema Verma has similarly underscored the need to move from fee-for-service to value. And the new head of the Innovation Center, Adam Boehler, comes from a background of using person-level payments to support care improvements for high-need patients.

The question is no longer whether CMS will proceed with VBP, but rather what form it will take. CMS continues to digest the comments from its New Directions for Innovation Center request for information, with one early initiative examining Direct Provider Contracting with primary care and multispecialty groups. While the details of this model are still in flux, it could be an opportunity for many practices to gain more flexibility and accountability for the care of defined groups of patients. Some of these payment models—addressing specialized care—could constitute more advanced payment models for providers as an alternative to the Merit-Based Incentive Payment System (MIPS).

More growth in bundled and specialized-care payment reforms can complement ACO and primary care payment reforms. Indeed, many successful ACOs are primary care groups, and moving away from fee-for-service payment for specialized care can help align specialists and hospitals with their primary care counterparts in pursuit of population health goals.

In addition, regulatory changes are likely coming soon to the flagship Medicare ACO program, the MSSP. This is likely because the

program's savings to date have been modest, although the most recent results have the program close to breaking even compared to benchmarks, and studies suggest ACOs are saving money compared to control groups. Judging from public statements by CMS and others in the administration, the major changes will likely focus on transitioning ACOs from one-sided risk (shared savings only) toward meaningful two-sided risk (shared savings and losses) as they remain in the program for longer. If risk is required, some ACOs will drop out. However, those may be "ACOs in name only," with MSSP allowing their physicians a reporting alternative to MIPS and with only limited changes in their care delivery.

Looking ahead, faster progress in care reform is possible. Public and private payers could refine payment models to provide a clearer path to success in taking on some financial risk and create a more coherent set of complementary payment reforms. Providers can seek to learn more from the organizations that are succeeding.

Authors' Note

This post was accepted for publication prior to the August 9 announcement by CMS

administrator Seema Verma regarding changes to the ACO program.

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Jeff Goldsmith • 6 hours ago

Authors could help the field evaluate the societal benefits of the ACO by surveying the ACO community and finding out their cumulative investment to date in setting up and operating ACOs, and the economic returns generated by them. This would enable calculation of the ROI for providers in creating ACOs. Early studies of the model, such as the Physician Group Practice (PGP) demonstration, did so, but since the MSSP program, there has been a studied avoidance of the cost question by ACO advocates.

If memory serves, the original CBO mark for MSSP was that ACOs would save the Medicare $5 billion over ten years. So far, the various versions of the MSSP program has cost the federal government around $400 million, counting the cost of the bonuses and the "overruns" by unsuccessful ACOs. We are unlikely to come within a country mile of the CBO mark.

A wild guess is that the provider community has spent around $10 billion setting up and operating ACOs, costing clinician time in documenting, communicating and meeting to govern them at zero. It would be great to have some real data. From a societal standpoint, my suspicion is that the ACO as a model is still deeply in red ink. So the question is: what is the fiscal and social justification for

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